Internal Audit Report

Maricopa Integrated Health System Review of Selected Contracts

- Long-Term Care Providers
- ValueOptions (Behavioral Health)

November 2004

Audit Team Members

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November 19, 2004

Andrew Kunasek, Chairman, Board of Supervisors
Fulton Brock, Supervisor, District I
Don Stapley, Supervisor, District II
Max W. Wilson, Supervisor, District IV
Mary Rose Wilcox, Supervisor, District V

We have completed our review of selected Maricopa Integrated Health System (MIHS) contracts with long-term care providers (nursing home and assisted living facilities), and with ValueOptions (behavioral health). The audit was performed in accordance with the annual audit plan approved by the Board of Supervisors. Highlights of this report include the following:

- Contract monitoring activities are not adequate to detect errors in payments to service providers
- Errors in payments made to one assisted living facility exceeded 70 percent
- Errors in payments made to nursing homes could be costing the County more than $1 million each year

This report contains an executive summary, specific information on the areas reviewed, and the MIHS response to our recommendations. We appreciate the excellent cooperation provided by MIHS management and staff. If you have any questions, or wish to discuss the information presented in this report, please contact Eve Murillo at 602-506-7245.

Sincerely,

Ross L. Tate

Ross L. Tate
County Auditor

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Executive Summary

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Maricopa Integrated Health System (MIHS) does not adequately ensure that payments to long-term care providers are accurate. Based on the sample of payments we tested, MIHS may be overpaying providers by as much as $1.5 million annually. MIHS should strengthen controls over their payment processes and recover any overpayments.

Payment Processing Procedures (Page 5)

MIHS payment processing procedures and contract oversight activities are not adequate to detect duplicate or inaccurate payments. Based on the sample we tested, one provider had errors in 70 percent of its payments. MIHS should strengthen controls over its payment process and recover any overpayments.

Contract Revenue (Page 7)

Controls over billings and collections for one of the County's behavioral health providers (ValueOptions) appear to be adequate. Based on the sample we tested, the MIHS Desert Vista Behavioral Health Center is currently processing bills and collecting revenues accurately and timely.

Introduction

Background

MIHS has contracts with approximately 1,200 vendors including medical care providers, medical/specialty services, nursing care facilities, assisted living homes, nurse registries, and doctors' pools.

Long-Term Care Providers

MIHS health plans have contracts with long-term care providers. The largest contract categories are:

- Institutional providers (nursing homes)
- Home and community based service providers (assisted living facilities, adult foster care homes, and attendant care)

As of May 2004, MIHS health plans expended $107 million for long-term institutional care providers and $60 million for home and community based service providers in FY 2004.

Behavioral Health Providers

MIHS owns the Desert Vista Behavioral Health Center which provides mental health and substance abuse treatment services. Desert Vista's largest source of revenue, approximately $15 million in FY 2003, is a contract with ValueOptions, the Regional Behavioral Health Authority in Maricopa County.

Selection of Contracts for Review

The selection of contracts for this report was the result of a formal risk assessment process. Internal Audit engaged Protiviti Inc., an outside consultant with health care expertise, to conduct a risk assessment of MIHS contracts and to assist with reviewing contracts. The following contracts were selected for review from high-risk service groups:

- Residential nursing facility contracts
  - Share of Cost (client portion of costs) provisions related to nursing homes (Issue 1)
  - Heather Glen (Issue 2)
  - Life Care Centers of America–North Glendale (Issue 2)
- Assisted living facility contract: Shadow Mountain (Issue 2)
- Large revenue contract: ValueOptions (Issue 3)

Scope and Methodology

The objectives of this audit were to determine that:

- Claims are paid in accordance with contract terms
- Share of Cost amounts (client portion of costs) are accurately accounted for and deducted from MIHS claim payments to nursing homes
- Controls over billing, revenue recognition, and revenue collections for ValueOptions are adequate

This audit was performed in accordance with generally accepted government auditing standards.

Issue 1 Share of Cost

Summary

Maricopa Integrated Health System (MIHS) does not adequately ensure that payments to long-term care providers are accurate. Based on the sample of payments we tested, MIHS may be overpaying providers by as much as $1.5 million annually. MIHS should strengthen controls over their payment processes and recover any overpayments.

Background

Arizona Health Care Cost Containment System (AHCCCS) is the state's Medicaid program. Maricopa County Long Term Care (MLTCP) is a contracted AHCCCS program manager with 6,744 enrollees as of April 2004.

Enrolled MLTCP members with incomes over the AHCCCS eligibility limit are required to contribute to their nursing home or assisted living facility room and board expenses. The member's portion of the expense is called "Share of Cost." Approximately 2,300, or 34 percent of MLTCP members are liable for Share of Cost contributions. According to AHCCCS data, MLTCP members' 2003 Share of Cost expenses averaged approximately $1.9 million per month or $22 million per year.

Example

AHCCCS assigns a 72-year-old member a monthly Share of Cost amount of $500 based upon the member's income level. The nursing home where the member resides submits a claim to MIHS (MLTCP) for $3,000. MIHS should subtract the member's monthly Share of Cost amount, $500, from the provider's monthly contracted rate, $3,000, and issue a check to the provider for $2,500. The nursing home is responsible for collecting the $500 from the member.

Audit Testing Results

OAO is the Health Plans' claims payment system. We compared our sample of OAO processed claims with AHCCCS-provided Share of Cost data and noted problems in the following areas:

- Loading and maintaining accurate AHCCCS Share of Cost data in OAO
- Applying Share of Cost data correctly to the claim

We sampled 112 claims processed during August 2002 through February 2004. Forty-six of the 112 claims sampled (41%) contained payment or system errors. Reviewed payments showed a 9.4 percent error rate by dollars (the remaining errors are related to incorrect claim payment system data). Based on the 8.3 percent overpayment error rate in the sample of payments we tested (see following table), MIHS may be overpaying providers by as much as $1.5 million annually.

Impact on MIHS

The following table summarizes the financial impact of the Share of Cost claims' exceptions:

Share of Cost (SOC) Claim Payment Test Results

	Claim Underpayment	Claim Overpayment	Combined Errors
Payment/Data Errors	$ 863	$ 6,182	$7,045
Total Sampled Dollars	$74,919	$74,919	$74,919
Calculated Error Percent	1.1%	8.3%	9.4%

In addition to payment errors, we noted numerous OAO system data inconsistencies. These inconsistencies, while not affecting reviewed claim payment amounts, still indicate that OAO contains incorrect data. Some examples are:

- Twelve instances in which the health plan member's history in the OAO system shows a Share of Cost amount in a month in which there was no claim and no Share of Cost. This appears to be an OAO system logic error.
- Nineteen instances in which the member's Share of Cost history in the OAO system shows no Share of Cost, yet the correct Share of Cost amount was applied to the claim payment.

Sources of Errors

MIHS is not consistently processing correct Share of Cost deductions from claims for the following reasons:

- OAO inconsistently processes Share of Cost data in the history table.
- Claim or billing reversals appear to prevent OAO from recognizing Share of Cost applied amounts within the system.
- Manual Share of Cost adjustments are not adequately documented and are occasionally mis-keyed.
- MIHS does not have an adequate Share of Cost proration policy covering members that are discharged mid-month.

Recommendations

MIHS should:

A. Develop policies and procedures to ensure Share of Cost claims are accurately processed.

B. Validate the accuracy of the claims system Share of Cost data and verify OAO program logic to determine if the Share of Cost applied amount calculation is working correctly.

Issue 2 Claims and Contract Oversight

Summary

MIHS payment processing procedures and contract oversight activities are not adequate to detect duplicate or inaccurate payments. Based on the sample we tested, one provider had errors in 70 percent of its payments. MIHS should strengthen controls over its payment process and recover any overpayments.

Audit Testing Results

We reviewed the following long-term care contracts:

- Heather Glen (residential nursing facility)
- Life Care Centers of America - North Glendale (residential nursing facility)
- Shadow Mountain Assisted Living (assisted living home)

We sampled calendar year 2003 claim payments for accuracy and timeliness. Our findings are summarized in the following table:

Contract	Dollars & # Claims Tested	Duplicate Payments	Late Payments *	Claim Rate Errors	Share of Cost Errors
Heather Glen	$259,010 (75 claims)	$12,227	49 (65%)	($200) underpaid	$395 overpaid
Life Care	$244,842 (75 claims)		13 (17%)	($2,268) underpaid	($423) underpaid $864 overpaid
Shadow Mountain	$13,306 (15 claims)		5 (33%)	($45) underpaid $255 overpaid	$9,055 overpaid (70% error)
Total	**$517,158 (165 claims)**	**$12,227**	**67 (40%) exceeded deadline goals**	**($2,513) underpaid** **$225 overpaid**	**($423) underpaid** **$10,314 overpaid**

* Exceeded system goals of 15 or 30 days.

Reviewed payments showed a relatively low error rate for Heather Glen and Life Care Center (5% and 1.5% respectively), although one Heather Glen claim was paid four times. The Shadow Mountain Assisted Living center payment error rate was considerably higher at 70 percent.

The errors occurred because MIHS did not accurately deduct clients' Share of Cost contributions from payments. Of the 15 Shadow Mountain claims sampled, 9 (60%) incorrectly deducted members' room and board cost (Share of Cost) resulting in an overpayment of $9,055. Furthermore, it appears that MIHS did not go through proper contractual procedures to include Shadow Mountain in its Senior Paradise Living contract.

Recommendations

MIHS should:

A. Establish controls to ensure that claim payments are 1) paid on time, 2) paid only once, and 3) paid according to contract terms.

B. Verify program logic to ensure that the system contains current contract rates.

C. Recover any net overpayments by obtaining refunds or by applying overpayments to future claims payments.

D. Amend the Senior Paradise Living contract to include the Shadow Mountain Assisted Living site.

Issue 3 ValueOptions Revenue

Summary

Controls over billings and collections for one of the County's behavioral health providers (ValueOptions) appear to be adequate. Based on the sample we tested, the MIHS Desert Vista Behavioral Health Center is currently processing bills and collecting revenues accurately and timely.

The Contract

MIHS Desert Vista Behavioral Health Center provides mental health and substance abuse treatment services. Its largest source of revenue, approximately $15 million in FY 2003, is a contract with ValueOptions, the Regional Behavioral Health Authority in Maricopa County. Desert Vista bills ValueOptions based on the average daily census of ValueOptions inpatients admitted to the Desert Vista facility.

Billings and Collections

We reviewed the accuracy of Desert Vista's billing records for 50 ValueOptions patients and verified that the Desert Vista business office:

- Obtained ValueOptions client eligibility confirmation
- Obtained all applicable Certification of Need or Recertification of Need forms
- Ensured that ValueOptions paid Desert Vista's claims

All reviewed records showed timely filing of Certificate of Need or Recertification of Need forms. The records also showed that consumer eligibility verification had been performed and approved by ValueOptions.

We determined that contract rates reconciled to monthly billings, cash receipts, and accounts receivable for FY 2003 and FY 2004 through April.

We reviewed Desert Vista's collection of amounts due from ValueOptions. Fifteen of 50 patient claims we examined had outstanding balances in the MIHS system totaling approximately $500,000 and averaged 3 months old. We reviewed system notes and validated that each of the 15 pended sample claims were actively reviewed and worked towards a resolution. Accounts receivable due at the end of FY 2003 were collected in full by September 2003.

Recommendation

None, for information only.

Department Response

MARICOPA
INTEGRATED
HEALTH SYSTEM

Count on us to care.

Maricopa Medical Center
2601 E. Roosevelt St.
Phoenix, AZ 85008
(602) 344-5011

Comprehensive Healthcare Center
2525 E. Roosevelt St.
Phoenix, AZ 85008
(602) 344-1015

Desert Vista Behavioral Health Center
570 W. Brown Rd.
Mesa, AZ 85201
(480) 344-2000

MIHS Health Plans
- **Maricopa Health Plan**
- **Maricopa Long Term Care Plan**
- **Maricopa Senior Select Plan**

2502 E. University Dr., Suite 125
Phoenix, AZ 85034
(602) 344-8700

Attendant Care
2611 E. Pierce St.
Phoenix, AZ 85008
(602) 344-2700

Arizona Integrated Pharmacy
2611 E. Pierce St.
Phoenix, AZ 85008
(602) 344-2500

Family Health Centers

Avondale
(623) 344-6800

Chandler
(480) 344-6100

El Mirage
(623) 344-6500

Glendale
(623) 344-6700

Guadalupe
(480) 344-6000

Maryvale
(602) 344-6900

McDowell
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Mesa
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Sunnyslope
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November 9, 2004

Ross Tate
County Auditor
Internal Audit Department
Maricopa County
301 West Jefferson St.
Phoenix, AZ 85003-2143

Dear Mr. Tate:

Thank you for the opportunity to respond to this recently completed audit. Attached is our response to the recommendations of your audit team.

We are all well aware of the provider payments issues associated with OAO. Your audit report served to validate the critical issues to improve the provider payment process. We are taking aggressive steps to resolve these long standing issues. Our detailed response to your recommendations is attached.

Sincerely,

Phyllis Biedess
Chief Executive Officer
Maricopa Health Plans

c. Mike Schaiberger, Doug Womer, Al Steindorf, Lynn Allen, Ernie Prindle

Issue #1:
Maricopa Health Plans does not adequately ensure that payments to long-term care providers are accurate.

Response: Concur. The issues relating to claims payment resulting from problems associated with the OAO system are well documented. To resolve these issues and improve the overall efficiency and effectiveness of the claims process the Department has taken a number of steps as detailed below:

1. A contract with AmeriHealth Mercy Health Plan to process provider claims has been issued. AmeriHealth will begin processing claims on December 1, 2004 for services provided to plan members after July 1, 2004. Pending implementation of this contract, the Health Plans' are continuing to pay all provider claims and a reconciliation will be completed for the period July 1, 2004 to December 1, 2004 after the AmeriHealth contract is implemented to ensure that all payments are properly accounted for.

2. To resolve all claims for services provided prior to July 1, 2004 the Department is reconciling each Nursing Home account. This reconciliation of each provider account ensures that all overpayments, duplicate payments, underpayments and share of costs are calculated and a payment to the provider or the Health Plans' is made to cover the outstanding balance. To date ten Nursing Home reconciliation's have been completed.

3. On May 1, 2004 a Roster Billing Program for the Nursing Facilities that serve Maricopa Health Plans' members that were provided service on or after April 1, 2004, was implemented. On August 1, 2004 the Roster Billing Program became mandatory and 100% of the contracted Nursing Facilities began participating in the Roster Billing Program.

   The Health Plans' have worked to enhance the Roster Billing Program since it debuted in May. On October 1, 2004 the Health Plans' introduced a web-based model of the Roster Billing Program. With this change, all Nursing Facilities are required to submit claims to the Health Plans' using the internet version of the Roster Billing Program. This Program has the following major components:

   - ✓ Roster Billing Records for the prior month are generated on the 1st business day of each month utilizing authorization data that our Case Managers enter into the Care Management System (CMS) operated by the Health Plans'.

- ✓ Roster Billing Records are published on the Roster Billing Website and are available for Nursing Facility review by 12:00 p.m. on the 1st business day of each month.
- ✓ The Nursing Facility reviews, validates, and corrects as necessary the information contained on the website for each member that will be billed to the Health Plans, including the accounting for share of cost. Each month AHCCCS provides the Department electronically the Share of Cost requirement for each member. This amount is electronically deducted from the amount due each facility. At times the Facility works in collaboration with the Case Manager and the Nursing Facility Claims Analyst at the Health Plan on Change Requests.
- ✓ The Nursing Facility submits completed Roster Billing Records to the Health Plan through the Roster Billing Program website.
- ✓ The Health Plan receives and processes submitted Roster Billing Records, producing a check which is remitted to the Nursing Facility.
- ✓ The Health Plan submits Encounter Data to AHCCCS for all relevant Roster Billing records.

Recommendation A: Develop policies and procedures to ensure that Share of Cost claims are accurately processed.

Response: Concur – Detailed procedures have been included in the Roster Billing Program to properly account for the Share of Cost.

Target Completion Date: Implemented as of May 1, 2004.

Benefits/Costs: Ensure that Share of Cost claims are accurately processed.

Recommendation B: Validate the accuracy of the claims system Share of Cost data and verify OAO program logic to determine if the Share of Cost applied amount calculation is working correctly.

Response: Concur with modification. As stated above the Department will no longer use OAO to process claims provided after July 1, 2004. The Roster Billing Program is being used to process Nursing Home claims and procedures have been included in this program to ensure the proper accounting for Share of Cost claims.

Target Completion Date: Implemented.

Benefits/Costs: Ensure that claims will be processed accurately.

Issue #2:
Health Plans payment processing and contract oversight activities are not adequate to detect duplicate or inaccurate payments.

Response: Concur.

Recommendation A: Establish controls to ensure that claim payments are 1) paid on time, 2) paid only once, and 3) paid according to contract terms.

Response: As detailed above the Health Plans' will use AmeriHealth and Roster Billing Program to process provider claims. We believe that controls are in place in these systems to ensure appropriate and timely payments.

Target Completion Date: December 1, 2004

Benefits/Costs: Ensure appropriate and timely payments.

Recommendation B: Verify program logic to ensure that the system contains current contract rates.

Response: Concur. Claims/contract staff is currently working with AmeriHealth to ensure that current contract rates are implemented in the new claims system.

Target Completion Date: December 1, 2004

Benefits/Costs: Enhanced profitability by ensuring proper payment of all claims.

Recommendation C: Recover any net overpayments by obtaining refunds or by applying overpayments to future claims payments.

Response: Concur. In process. See response to Recommendation #1 for details.

Target Completion Date: December 1, 2004

Benefits/Costs: Ensure appropriate payment for services rendered.

Recommendation D: Amend the Senior Paradise Living contract to include the Shadow Mountain Assisted Living site.

Response: Concur. Contract Administration staff will amend the Senior Paradise Living contract retroactively to the day that the Shadow Mountain site was added to the parent contract.

Health Plan Response
MIHS – Review of Selected Contracts

Target Completion Date: December 1, 2004

Benefits/Costs: Improved contract compliance.

Approved By :

Refer to signature on cover memo	11/9/04
Department Head/Elected Official	**Date**
D R Smith	11/16/04
County Administrative Officer	**Date**